To speed enrollment process, please be thorough and fill out all sections that apply.

☐ **Enroll** ☐ **Cancel** ☐ **Change**

☐ **Address Change** ☐ **Name Change** **Date of Change**____/___/____

A. Employee Information

First Name | M.I. | Last Name | Social Security #/Employee ID #

Street Address | Apt. # | City | County | State | Zip | Country

Home Phone | Work Phone | How many hours do you work per week? | Email Address ☐ Home ☐ Work

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed | Sex ☐ M ☐ F | Birthdate | Physician* | Are you a current patient? ☐ Yes ☐ No

B. Family Information

Dependents to be enrolled, cancelled, changed: (Attach sheet if necessary)

Check appropriate box	Last Name First Name M.I. / Dependent Social Security No.	Sex	Birthdate	Relationship**	Full-Time Student	Physician*	Are you a Current Patient?
☐ Enroll ☐ Cancel ☐ Change	SS# | | | | – | | – | | | |	M F			☐ Yes ☐ No School Name:		☐ YES ☐ NO
☐ Enroll ☐ Cancel ☐ Change	SS# | | | | – | | – | | | |	M F			☐ Yes ☐ No School Name:		☐ YES ☐ NO
☐ Enroll ☐ Cancel ☐ Change	SS# | | | | – | | – | | | |	M F			☐ Yes ☐ No School Name:		☐ YES ☐ NO

***IMPORTANT: Please use the UnitedHealthcare directory of providers to choose a Primary Physician (Primary Care), for yourself and each of your covered dependents for UnitedHealthcare Select and Select Plus only. **For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on separate sheet.**

C. Product Selection (check all that apply)

MEDICAL BENEFITS:
- ☐ Employee Only Coverage
- ☐ Employee/Spouse Coverage
- ☐ Employee/Children Coverage
- ☐ Employee/Spouse/Children Coverage
- ☐ **No Medical Coverage (complete Section E)**

DENTAL BENEFITS:
- ☐ Employee Only Coverage
- ☐ Employee/Spouse Coverage
- ☐ Employee/Children Coverage
- ☐ Employee/Spouse/Children Coverage
- ☐ No Dental Coverage

- ☐ I decline coverage for myself
- ☐ I decline coverage for my spouse
- ☐ I decline coverage for my children

Reason: ☐ Covered under another plan ☐ Other: _____

LIFE INSURANCE PRODUCTS

Salary $_____ ☐ wk ☐ mo ☐ yr

- ☐ Life/Accidental Death or Dismemberment
- ☐ Dependent Life Insurance
- ☐ I decline coverage for myself
- ☐ I decline coverage for my dependents

Reason ☐ Covered under another plan ☐ Other: _____

Life Beneficiary's Full Name and Address | Relationship

EMPLOYER USE ONLY

Benefit Level/Class Code

OVERTURE PLAN DESIGN (Check one selection if your employer has offered an Overture Package.)

☐ UnitedHealthcare Overture Classic ☐ UnitedHealthcare Overture Performance ☐ UnitedHealthcare Overture Premier

D. To Be Completed By Employer

Company Name | Group # | Plan Variation Medical _____ Dental _____ | Reporting Code Medical _____ Dental _____ | Department #

New Enrollment/Additions: (Check one)

Date of Hire ___/___/___ Requested Date of Coverage ___/___/___

- ☐ New Hire ☐ Status Change (PT to FT)
- ☐ Return from Leave/Layoff ☐ Loss of Coverage (describe)_____
- ☐ Birth ☐ Marriage ☐ Adoption (attach legal documentation)
- ☐ Court ordered dependent (attach documentation)
- ☐ Other (describe) _____

(attach COBRA Election Form)

- ☐ COBRA/Continuation start date _____ stop date_____
- ☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___/___/___

☐ **Cancellations:** Last Date of Employment ___/___/___

Requested Effective Date of Cancellation ___/___/___

- ☐ Cancel all coverage
- ☐ Cancel listed above – Section B

Reason: (check one)

- ☐ Death ☐ Employee Terminated ☐ Divorce
- ☐ Moved out of service area
- ☐ Dependent reached student/dependent max age
- ☐ Other (describe)_____

Product Selections – Check all that apply | ☐ Union ☐ Non-union | ☐ Salaried ☐ Hourly | ☐ Active ☐ Retire Date _____

- ☐ UnitedHealthcare Choice+
- ☐ UnitedHealthcare Select+
- ☐ UnitedHealthcare Managed Indemnity^
- ☐ UnitedHealthcare Select Plus^
- ☐ UnitedHealthcare Overture^ Package _____ (A-S)
- ☐ UnitedHealthcare Choice Plus^
- ☐ UnitedHealthcare Options PPO^
- ☐ UnitedHealthcare Options PPO 80/80^
- ☐ [UnitedHealthcare Rhapsody^]

DENTAL PLANS

- ☐ UnitedHealthcare Dental Managed Indemnity^
- ☐ UnitedHealthcare Dental Options PPO^

+Provided by UnitedHealthcare of the Midlands, Inc.;
^Provided by United HealthCare Insurance Company

Applicant Name _____

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm employee completed the appropriate information. 2) Complete section D. 3) Please provide your signature and today's date.

Signature _____ Date _____

Employer Position_____ Phone Number_____

E. Other Medical Coverage Information / Waiver (This section must be completed; if not, claims will be denied.)

Have you or your dependents had any other medical coverage in the last 12 months? ☐ YES ☐ NO Will this coverage be terminated? ☐ YES ☐ NO

Insurance Company Name (use extra paper if needed)	Coverage Start Date	Coverage Stop Date	If Yes, Date

Coverage type: ☐ Group Policy ☐ Individual Policy ☐ Medicare/Medicaid ☐ Other_____

Is this coverage through your spouse's employer? ☐ YES ☐ NO If yes, please provide employer's name	Name, date of birth and Social Security # of policy holder
Employee's relationship to policyholder	Names of family members with other continuing medical coverage (Including Medicare)

Medicare effective date Parts A&B	Reason for Medicare eligibility: ☐ Over 65 ☐ Disabled ☐ Kidney Disease	Medicare Claim #

WAIVER **I decline to enroll for this coverage for myself, my spouse, and my dependent children due to:**

☐ Existence of other health coverage ☐ Spousal coverage ☐ Other Reason (Explain) _____

Check one of the above boxes, then read and sign.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption. I have read and understand the "Important Information"located on the back of this form.

X Employee Signature_____ Date Signed_____

(only sign if you are waiving coverage)

F. Medical Research Studies / Additional Products & Services

☐ **Please do not send me information regarding medical research studies.**

☐ **Please do not send me information regarding additional products and/or services.**

Signature (Form must be signed)

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Date _____ **Employee Signature** _____ **Spouse Signature** _____

(if possible) and applicable